VERMONT HIV/AIDS ASSISTANCE PROGRAMS
Instructions

Program Selection

Indicate which program you are applying to. You may apply to either or both. If you applying for the **AIDS Medication Assistance Program (AMAP)**, you are encouraged to apply for the **Dental Care Assistance Program (DCAP)** as well.

Vermont Residency/Insurance and Contact Information (**Section A**)

Verification of Vermont residency is necessary. Please send a copy of a utility bill, income tax form, VT drivers or non-drivers license or another document that would verify your Vermont residency. Length of residency in Vermont will not effect your eligibility for this program. If you are covered under a private insurance, please include **copy of your insurance card, front and back**.

List of Medications **(Section B)**

Please list all medications which you are taking including both prescription and non-prescription medications. Include the monthly cost of these medications to you (either actual cost of the medication or the copay that you pay). You may use this amount on Line E(i) as a deduction on the Financial Information page.

Household Members **(Section C)**

List all individuals for whom you are financially responsible or who is responsible for you. Include yourself, a married spouse, or civil union partner, and any legal dependents.

Income **(Section D)**

List all income received by you and/or your legal spouse. You may use income in the prior month to determine annual income. If changes have occurred or are expected to occur so that prior months income is not reflective of annual income, please provide an explanation and estimate. If you are self employed, please indicate type of business and provide gross and net income for the three months prior to application. Other income includes other unearned income, alimony, pensions, rental income, cash/check from others. **Verification of all income must be included with your application and may include paystubs, W-2's, written employer statements, self-employment business records, and award letters such as Social Security, SSI, or VA award letters.**

Verification of HIV status

Have your physician or other medical provider sign the Verification of HIV Status Form and return it with your completed application.

Disclosure of Information

Fill out and sign the enclosed Release of Information form. **Only information that is necessary to determine eligibility and billing would be disclosed.** Include anyone with whom you may want us to speak. If their name does not appear on the release, we may not speak with them.

Requirement to Report Change

If you are found eligible for the Assistance Programs, you will be responsible for reporting any changes in your residence, income, health insurance coverage, or other circumstances affecting eligibility within 10 days of the change. Failure to do so may result in your becoming ineligible, and required to reapply.

Photocopies are acceptable for all verifications.

Mail your application to:

Moretti
VT Dept. of Health
108 Cherry St., Drawer 41 HAST
P.O. Box 70
Burlington, VT 05402-0070
(802-863-7253 or 800-464-4343 ext 7253)

VERMONT HIV/AIDS ASSISTANCE PROGRAMS
Application

Program Selection: To which program are you applying (may be either or both)

❒ **AMAP** **(AIDS Medication Assistance)**

❒ **DCAP** **(Dental Care Assistance)**

A) Last Name:_____First:_____MI:._____ SSN:_____-___-_____

Street Address: _____City:_____State:____ Zip:_____

Mailing Address:_____City:_____ State:____ Zip:_____

Do you currently live in Vermont? ❒ No ❒ Yes Date residency in Vermont began: _____/_____
(*Duration of Vermont residency does not affect eligibility for this program)* Month/ Year

Telephone # (day): (____)_____ Can a message be left at this number (name & tel. # only)? ❒ No ❒ Yes

Telephone # (eve): (____)_____ Can a message be left at this number (name & tel. # only)? ❒ No ❒ Yes

Date of Birth:____/_____/_____

Gender: ❒ Male ❒ Female ❒ Transgender

What is your marital status? ❒ Single ❒ Married ❒ Involved in a civil union

The following two questions are for reporting purposes only and does not affect eligibility. You may check more than one.

Are you Hispanic or Latino? ❒ Yes ❒ No

What is your race?
❒ American Indian or Alaska Native
❒ Asian
❒ Black or African American
❒ Native Hawaiian or Other Pacific Islander
❒ White

Were you were ever in the military? ❒ Yes ❒ No

If yes, did you receive an honorable discharge? ❒ Yes ❒ No
(If so, you may be eligible to receive all of your medications free of charge from the VA)

If you are found eligible for AMAP and/or DCAP, what date will you need coverage to begin?_____

Do you currently have *health insurance*, including Medicare? ❒ Yes ❒ No
(<u>Please send copy of insurance card</u>)

Insurance Co. Name: _____

Address:_____ Telephone #:_____

Policy #:_____Group #:_____

Name of policy holder:_____ Start Date of Insurance:___/____/___

Social Security # of policy holder: : _____-___-_____

Does your health insurance cover *prescriptions*? ❒ No ❒ Yes

If yes, what is the coverage?_____

Date eligible to receive prescription coverage:_____

Name of Prescription Insurance carrier (if other): _____

Telephone #:_____

You will be asked to have your prescriptions filled at only one pharmacy. Please indicate:

Name of Pharmacy: _____ Telephone:_____

Address: _____

Do you currently have *Dental Insurance*, including Medicare? ❒ Yes ❒ No
(<u>Please send copy of insurance card</u>)

Insurance Co. Name: _____

Address:_____ Telephone #:_____

Policy #:_____Group #:_____

Name of policy holder:_____ Start Date of Insurance:___/____/___

Social Security # of policy holder: : _____-___-_____

Do you currently have, or have you ever applied for, any of the following?

	Date of Last Application	Eligibility Date	Date Coverage Ends	Reason for denial (if applicable)
VHAP				
VHAP Pharmacy				
Vscript				
Medicaid				
Other assistance Program				

Please list the following contacts where appropriate:

	Name	Address	Telephone
Primary Care Physician			
HIV Specialist Physician			
Dentist/Oral Surgeon			
DSW eligibility worker			
Case manager*			

**someone from an AIDS service organization or social worker where you receive medical care*

B) **MEDICATION INFORMATION**

Please list all medications which you are taking (include prescription and non-prescription medications) and their **monthly** cost to you. Please deduct the amount your health insurance company will pay. You may use the total cost to you as a deduction on the Financial Information page.

Name of medication	Cost per month to you
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

TOTAL COST PER MONTH $ _____

ANNUAL COST (X 12 months) = $ _____ **(**Place this amount on Line E(i))

* **If you are currently not taking any medications, when do you expect to begin therapy?**

_____

FINANCIAL INFORMATION

C) List legal dependents, including your married spouse or civil unioned partner, if applicable:

Name	Relationship	Date of Birth	Social Security #

D) Annual Household Income (List all income received by you and/or married spouse/civil union partner, if applicable): ***Please see Instructions for filling out this section***

	Self	**Other**
a) Gross wages/salary	$_____	_____
b) *Self-employment	$_____	_____
c) Dividends/interest	$_____	_____
d) **Social Security	$_____	_____
e) **SSDI	$_____	_____
f) Veterans Benefits	$_____	_____
g) Unemployment	$_____	_____
h) Worker's Comp.	$_____	_____
i) Child Support	$_____	_____
j) Other	$_____	_____

*State Type of Business_____

**** If you are receiving SSI and/or SSDI, when did you become disabled? _____**

E) Deductions from Annual Household Income	**Self**	**Other**
a) State income taxes	$_____	_____
b) Federal income taxes	$_____	_____
c) Property taxes or 21% of rent <u>you</u> pay	$_____	_____
d) Social Security	$_____	_____
e) Medicare Tax	$_____	_____
f) Cost of medical insurance (inc. Medigap and Medicare)	$_____	_____
g) Cost of medical services (not covered by insurance)	$_____	_____
h) Cost of medical supplies (not covered by insurance)	$_____	_____
i) Cost of medications ("*Annual Cost" from Section B*)	$_____	_____
j) Child support payments	$_____	_____
k) Child care costs	$_____	_____

I solemnly swear that the information written on this form is correct and complete to the best of my knowledge. I understand that the information I have provided may be subject to verification in order to determine my eligibility for this program. I also understand that the information I have provided will be kept confidential and will only be used for the administration of this program.

Signature_____Date_____